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Supreme Court, U.S.
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CHARLES ELMORE CROPLEY

Supreme Court of the United States.

October Term, 1935.

No. 502.

New York Life Insurance Company,

Petitioner,

v.

Demetrios P. Viglas,

Respondent.

BRIEF FOR THE PETITIONER.

LOUIS H. COOKE,
F. H. NASH,
RICHARD WAIT,
Attorneys for Petitioner.

ALBERT C. ADDEMANN & SON, LAW PRINTERS, NEWARK.

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Supreme Court of the United States.

October Term, 1935.

No. 602.

NEW YORK LIFE INSURANCE COMPANY,
Petitioner,
v.
DEMETRIOS P. VIGLAS,
Respondent.

BRIEF FOR THE PETITIONER.

Jurisdiction and Travel of the Case.

This action at law, commenced in the District Court for the District of Massachusetts, comes before this Court upon certiorari to the Circuit Court of Appeals for the First Circuit. Jurisdiction of the Federal Courts is asserted by the respondent on the basis of diversity of citizenship (U.S.C. Tit. 28, § 41 (1)).

The writ is dated November 9, 1933 (R. 1). It named $15,000 as the ad damnum. The petitioner demurred to the declaration on the ground that it showed a cause of action on which no more than $98 could be recovered, so that the District Court was without jurisdiction (R. 7, 8). The District Court sustained the demurrer. Its opinion (R. 9, 10) is not reported. The respondent appealed to the Circuit Court of Appeals. That Court reversed the judgment of the District Court. Its opinion (R. 11-17) is reported 78 F. (2d) 829. Judgment was entered by the Circuit Court of Appeals July 13, 1935 (R. 17). A petition

for rehearing filed by the petitioner was denied without opinion October 9, 1935 (R. 18). This Court granted the petition for certiorari December 23, 1935 (R. 29).

Statement of the Case.

The substitute declaration (R. 3-7) is based upon a life insurance policy issued by the petitioner to the respondent (R. 19-27). Under this policy the petitioner undertook to pay the beneficiaries (who are not parties to the litigation) $2000 upon the death of the respondent, and "upon receipt of due proof that the Insured is totally and presumably permanently disabled" (R. 19, 20) to pay to the respondent himself $20 for each completed month of total disability and to waive payment of premiums (otherwise payable semi-annually) by the respondent throughout the continuance of the disability. Careful provisions were in the policy covering this obligation (R. 20). The promise is to pay the monthly annuity "for each completed month from the commencement of and during the period of continuous total disability" and to waive premiums "falling due during the period of continuous total disability" (R. 20). Before making payments (subject to certain conditions not presently material) the petitioner might require proof of the continuance of the disability. If the insured should perform any work, no further payments should be made.

The substitute declaration contains two counts. Under the first, recovery of only $1408 is sought, so it may be disregarded. In the second it is alleged that on September 11, 1931, the respondent "became totally and permanently disabled within the terms and provisions of the contract," and that thereupon the petitioner honoured the claim made, paid the $20 monthly annuity to and including July 11, 1933, and waived premiums falling due prior to August 7, 1933. It is then alleged—

". . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract. Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

This is followed by an allegation that the respondent was in fact totally disabled throughout, and consequently that the refusal of the benefits was a breach by the petitioner and that the respondent "elected to treat said wrongful refusal of the defendant [petitioner] to perform its obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6). Upon this basis entire damages were sought, based upon the respondent's life expectancy (thirty-six years) and his anticipation that he would remain disabled, amounting to some $15,900 (R. 7).

To this declaration the petitioner demurred (R. 7, 8) upon the ground that the allegations did not show a total breach and that the limit of the recovery on the allegations was the amount of accrued monthly payments and waiver of premium, amounting in all to $98, and so far below the jurisdictional requirement of more than $3000

(U.S.C. Tit. 28, § 41 (1)). As far as the demurrer is concerned, there has never been any dispute on the figures. The only question presented is whether the allegations show such a breach as to allow recovery of damages which would include future indemnity which might or might not accrue and become payable, depending upon future facts which cannot be prophesied with any exactness.

The District Court answered this question in the negative and sustained the demurrer (R. 9, 10). In support of the declaration the respondent relied heavily on the case of *Federal Life Insurance Company* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6). The District Court treated that case as such authority, but refused to follow it, on the ground that it was contrary to the weight of authority.

On the respondent's appeal to the Circuit Court of Appeals he took the same position and based his argument upon the authority of the *Rascoe* case. The argument took place before *Mobley* v. *New York Life Insurance Company* was argued in this Court. The opinion was handed down after the decision of this Court in the *Mobley* case. In the opinion (written by Judge Morton) it was held that the allegations showed a total breach and repudiation of the policy which entitled the respondent to the entire damages which he sought. The *Rascoe* case was not mentioned, and an attempt was made to distinguish the *Mobley* case.

Specification of Errors.

The Circuit Court of Appeals erred—

(1) In refusing to follow the decision of this Court in *Mobley* v. *New York Life Insurance Company,* 295 U.S. 632.

(2) In holding that the declaration showed a repudiation of its contract by the petitioner upon allegations, without more, that (*a*) the respondent was entitled to continue to receive disability benefits from the petitioner, but that

(*b*) the petitioner refused to continue the benefits upon the ground (not alleged to have been taken *mala fide*) that the respondent had not met the conditions upon which only the benefits were payable, and (*c*) thereafter, upon failure to receive a premium, declared the policy lapsed.

(3) In ruling that, upon a total breach of a policy providing for monthly future payments conditioned upon the state of health of the policyholder at the beginning of each future month, the present value of those future payments, computed upon the assumption that the policyholders will live out the normal expectancy of an unimpaired life and continue to suffer total disability, may be recovered.

(4) In reversing the judgment of the District Court and ordering the petitioner's demurrer to the substitute declaration overruled.

Points and Authorities.

1. *The case is governed by the decision of this Court in the recent case of Mobley v. New York Life Insurance Company, 295 U.S. 632.*

The precise question presented upon the present record was before this Court in the case of *Mobley* v. *New York Life Insurance Company*. It will be observed that the insurer was the same in both cases. The policy provisions in the instant case cannot be described more succinctly than by following the language of the Court in that opinion. The policies held by both Mobley and Viglas provided—

> "That whenever the insured is so disabled by bodily injury or disease that he is wholly prevented from performing any work, following any occupation or engaging in any business for remuneration and the company receives proof that this disability will continue for life or that it has existed for the three months next preceding the proof, the company will pay monthly

ten dollars per thousand of face value and waive premiums; that, before making any income payment or waiving any premium, the company may demand proof of continuance of total disability (but not oftener than once a year after disability has continued for two full years) and that, upon failure to furnish such proof, no further payments will be made nor premiums waived" (295 U.S. 635).

Mobley became disabled under circumstances which entitled him to receive the monthly payments provided in the policy. Thereafter a dispute arose between him and the insurer as to whether his disability was still persisting, and—

> "March 1, 1933, the company wrote him stating it appeared that for some time he had not been continuously disabled within the meaning of the policies, that no further monthly payments would be made and that the premiums due on and after February 7 became payable according to the terms of the contracts" (295 U.S. 635, 636).

On April 13 the company notified Mobley that the policy had lapsed. Mobley immediately seized upon the company's action as constituting a total breach of the policy which would entitle him to recover at that time indemnity for a further period figured upon the theory that he would continue disabled and would live out his normal expectancy. The District Court for the Southern District of Mississippi, the Circuit Court of Appeals for the Fifth Circuit, and this Court all ruled that there could be no such recovery. This Court said in its opinion:

> "The evidence gives no support to the claim that it disregarded or intended to break its promises. We conclude that, as found by the lower courts—rightly

declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in *Federal Life Ins. Co.* v. *Rascoe, supra,* [12 F. (2d)] 696—the company did not repudiate the policies. In view of that fact, we need not, and therefore do not, decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. *Dingley* v. *Oler, ubi supra,* [117 U.S. 490]'' (295 U.S. 639).

In the case at bar the respondent became disabled under circumstances which led the petitioner to make monthly payments to him under his policy. The petitioner received advices that his condition had improved and refused to make further payments. He brought suit, making the precise claim which Mobley had made. In his declaration he alleged—

''. . . that on or about September 1, 1933, the defendant refused to make the monthly payment due August 11, 1933, and refused to waive the semi-annual premium due August 7, 1933, asserting to the plaintiff as its ground for such refusal that since it appeared to the defendant that for some time past the plaintiff had not been continuously totally disabled within the meaning of the disability benefit provision of the policy, the defendant would make no further monthly disability payments, and that the premiums due on and after August 7, 1933, would be payable in conformity with the terms of the contract'' (R. 6).

Obviously no distinction can be drawn between these allegations of the respondent's declaration and the evidence tending to show breach summarized by this Court in the *Mobley* case.

The Circuit Court of Appeals referred to the opinion of this Court in the *Mobley* case, but did not make any attempt

to distinguish specifically between the allegations of the declaration which was before it and the facts on which this Court passed in the cited case. It contented itself with quotations from the opinion of this Court, laying down the broad general propositions of the law upon which such cases must depend and with the bare statement: "The facts alleged are essentially different from those in the *Mobley* case where it was held that the evidence did not show repudiation of the policy or a complete denial of liability on it by the company" (R. 15).

That statement is demonstrably not so. A comparison of the allegations of the breach in the respondent's declaration with the quotation from the opinion of this Court given above shows that there is no essential difference and indeed that both employ almost identical words. This is not extraordinary in view of the fact that both obviously were taken from the same form letter sent in such cases by New York Life Insurance Company to policyholders making claims like those of Mobley and the respondent.

The Circuit Court of Appeals made a point of the further allegation contained in the declaration that the petitioner had declared the policy lapsed upon its records. The allegation of the declaration on this point was as follows:

> "Upon the expiration of the days of grace after August 7, 1933, for the payment of the semi-annual premium, the defendant, on or about September 19, 1933, declared the policy as lapsed upon its records, the premiums not having been waived by the defendant nor paid by the plaintiff" (R. 6).

Referring to this allegation the Circuit Court of Appeals said:

> "As we construe the declaration it alleges a complete and unqualified denial by the defendant of all liability on the policy. It states that the defendant not

> only refused to pay benefits due but wrongfully lapsed the policy for non-payment of premiums. An unconditional lapsing of the policy was a complete termination of it and a denial by the defendant of any further liability on it. There is no allegation that the defendant recognizes any further rights of the plaintiff in the policy, or any further liability upon it. . . . On the allegations of the declaration we are of opinion that the plaintiff was entitled to maintain the action and, if the lapsing was found to be a complete and unqualified denial by the defendant of any further liability on the policy and was unjustified that the plaintiff would be entitled to recover damages equivalent to the value to him of the contract which was broken" (R. 15).

But this allegation in no way distinguishes the instant case from the *Mobley* case. There also the insurer declared the policy lapsed. In both cases the company was simply referring to the express provision contained in the policies that the policy should not remain in force beyond the date when the next premium payment should become due (R. 24). It is only by a clear misconstruction of the allegations of the declaration that it is possible to say that they show "a complete and unqualified denial . . . of all liability on the policy." The notification of September 1, 1933, specifically stated that it was sent upon the ground, not that there was anything wrong with the policy, but that the respondent was not then continuously totally disabled, and it was coupled with a statement that the premiums due thereafter would be payable "in conformity with the terms of the contract"—thus specifically recognizing that the policy was then still in force.

The further notification that the policy had lapsed, sent after the time for the payment of the premium had passed,

added nothing to the situation. If the premium was in fact payable, it was a simple notification that the policy had expired by its own terms. If, on the other hand, the premium should have been waived, it was entirely nugatory, added nothing to what had already gone before, and cannot be taken to indicate any intention on the part of the petitioner not to recognize its policy obligations.

The fact that it appeared in evidence in the *Mobley* case that after the insurer had refused to continue benefits and had notified Mobley of the lapse of its policy it reversed its decision and tendered benefits to Mobley, which were refused, forms the basis for no distinction between the two cases. Mobley brought his action on the basis that there had then accrued to him a complete cause of action to recover the entire amount sought, and that nothing done thereafter by the defendant could change the situation. It was on this basis that the case was decided. The behaviour of the insurer after the action was commenced was pertinent on the question of whether the original refusal to continue the benefits was made in good faith or not. In the present case this issue is not presented, since there are no allegations in the declaration that the petitioner did not act in good faith and the asserted ground of its action was one which was clearly open to it entirely irrespective of whether it may have been wrong in its understanding of the factual situation.

There are no allegations in the declaration that the petitioner took its position in anything other than entire good faith or that it intended to break its promises. The declaration shows a breach of the obligation to make current payments, but it does not purport to allege that the petitioner repudiated the contract. The *Mobley* case is controlling authority to the effect that no such breach as is alleged will warrant assessment of the damages sought.

2. The doctrine of anticipatory breach, which alone could sustain the respondent's position, does not apply to the case.

If, contrary to our submission, there are grounds upon which this case can be distinguished from the *Mobley* case, the action of the District Court in sustaining the demurrer was nevertheless correct.

The obligation which the petitioner undertook under the policy was a strictly conditional one. It was that *if* the respondent became totally and presumably permanently disabled, the petitioner would each month thereafter pay the respondent $20 *if* he was still disabled with the passage of each month. Until these conditions are met there is no present obligation on the insurer. Assume that on July 11, 1933, the respondent is so disabled as to entitle him to payments and has made proper proof of his condition. On that day (assuming it to be the last day of a "completed month" (R. 20) of disability) an obligation on the petitioner to pay $20 accrued. It was discharged by payment. On the next day, July 12, and until August 11 the petitioner was under no present obligation with reference to further payments. If the respondent continued disabled throughout the ensuing month, a new obligation to pay $20 would arise on August 11 on the completion of the month, but it would not arise until that day. And in the same way on August 12 there would be no present obligation with respect to a payment to be made on September 11.

The situation thus presented is to be distinguished from that found in cases like *Parker* v. *Russell,* 133 Mass. 74 (a contract to support for life), which the Circuit Court of Appeals considered controlling (see R. 16). That sort of case presents a situation where there is a present accrued obligation to make periodic payments in the future. There, if the party refuses to make a payment, there is a present breach of the single obligation and damages are immediately recoverable (see *Parker* v. *Russell,* 133 Mass. 74; *Pakas* v.

Hollingshead, 184 N.Y. 211; *Pierce* v. *Tennessee Coal &c. Co.,* 173 U.S. 1). But they are recoverable for reasons wholly unconnected with the doctrine of anticipatory breach. The obligation has accrued although the time for full performance has not yet arrived. No condition exists to interfere with the accrual of the obligation. But in the present case on August 12 the only accrued obligation is to pay the $20 due August 11. Although a further obligation to pay $20 on September 11 may accrue when that day arrives, it has not accrued on August 12 and cannot accrue until that day arrives, for only then can the condition be met. In effect the disability provisions of the policy constitute a series of contracts, one relating to each month and each subject to its own condition precedent. It therefore follows that on August 12 there can be no present breach of any obligation to make future payments. If there is any breach at all, it must be an anticipatory breach.

The only case before this one in which a Federal Court has allowed recovery of future installments of a disability annuity such as this placed its decision on the ground of anticipatory breach.

> *Federal Life Insurance Co.* v. *Rascoe,* 12 F. (2d) 693 (C.C.A. 6).

Later Federal cases discussing the point put it upon that same footing.

> *Kimel* v. *Missouri State Life Insurance Co.,* 71 F. (2d) 921 (C.C.A. 10).
>
> *Menssen* v. *Travelers Ins. Co.,* 5 Fed. Supp. 114 (E.D. N.Y.).
>
> *Kithcart* v. *Metropolitan Life Insurance Co.,* 1 Fed. Supp. 719 (W.D. Mo. W.D.).
>
> *Wyll* v. *Pacific Mutual Life Insurance Co.,* 3 Fed. Supp. 483 (N.D. Tex.).

Hines v. *Fidelity Mutual Life*, 6 Fed. Supp. 692 (E.D. N.Y.).

Smith v. *Mutual Benefit &c. Assn.*, 10 Fed. Supp. 110 (D.C. W.D. Okla.).

(In none of these cases was recovery allowed.)

The respondent argued the case in both the District Court and the Circuit Court of Appeals as a case of anticipatory breach. It was to provide a basis for that argument that the allegation that the respondent "elected to treat said wrongful refusal of the defendant to perform is obligations under said contract as a repudiation and renunciation of the entire contract" (R. 6) was inserted in the declaration.

It is well established that a party who asserts an anticipatory breach of a contract must show a clear, unequivocal repudiation of it by the other party. Nothing short of that will suffice.

Dingley v. *Oler*, 117 U.S. 490.

In that case the Court considered correspondence in which the defendant had refused to comply with the plaintiff's request, and said (at p. 502):

> "This, we think, is very far from being a positive, unconditional, and unequivocal declaration of a fixed purpose not to perform the contract in any event or at any time. In view of the consequences sought to be deduced and claimed as a matter of law to follow, the defendants have a right to claim that their expressions, sought to be converted into a renunciation of the contract, shall not be enlarged by construction beyond their strict meaning."

Nothing short of definite repudiation will suffice.

Johnstone v. *Milling*, 16 Q.B.D. 460.

This requirement was again affirmed in the *Mobley* case, where the Court said (295 U.S. 638):

> "Repudiation by one party, to be sufficient in any case to entitle the other to treat the contract as absolutely and finally broken and to recover damages as upon total breach, must at least amount to an unqualified refusal or declaration of inability, substantially to perform according to the terms of his obligation. *Roehm* v. *Horst,* 178 U.S. 1, 14, 15. *Smoot's Case,* 15 Wall. 36, 49. *Dingley* v. *Oler,* 117 U.S. 490, 503. *Kimel* v. *Missouri State Life Ins. Co.,* 71 F. (2d) 921, 923. Mere refusal, upon mistake or misunderstanding as to matters of fact or upon an erroneous construction of the disability clause, to pay a monthly benefit when due is sufficient to constitute a breach of that provision, but it does not amount to a renunciation or repudiation of the policy. *Daley* v. *People's Building, L. & S. Assn.,* 178 Mass. 13, 18; 59 N. E. 452."

The respondent by his allegations did not bring himself within this requirement. It has already been shown that the allegations of this declaration do not go beyond the proof considered in the *Mobley* case, which was held insufficient to constitute a repudiation. Here there is no allegation of any repudiation of the policy. It is simply alleged that "the defendant refused to make the monthly payment due August 11, 1933" (R. 6). And coupled with this is the further allegation that the refusal was because the respondent was not "totally disabled *within the meaning of the disability benefit provision of the policy*" (R. 6), and consequently no further payments would be made. But this shows beyond question that the refusal was based upon the letter of the contract. It was also alleged that with this refusal the petitioner notified the respondent that the premiums thereafter "would be payable *in conformity*

with the terms of the contract." This expressly recognized the continued existence of the policy as a binding contract. The petitioner was claiming the right reserved to it in the policy not to make payments unless the respondent was disabled. Such a claim in the nature of things could not constitute a repudiation of the contract. But nothing short of repudiation could justify recovery of more than overdue payments.

The further allegation that at the expiration of the grace the petitioner "declared the policy as lapsed upon its records, the premiums not having been waived . . . nor paid" (R. 6), adds nothing. Lapse is something which happens in accordance with the terms of a policy and is to be distinguished from repudiation. Lapse signifies termination of the policy in accordance with its provisions, not a repudiation which would terminate the contract contrary to its provisions.

The first requirement for a cause of action for anticipatory breach (that there be an unqualified repudiation of the contract by the defendant) is, therefore, lacking. But that is not the only lack apparent on this declaration. To show such a cause of action it is also essential that the contract contain mutual executory obligations. Where no obligation rests upon the plaintiff, as in the case of a holder of negotiable paper, the doctrine does not apply.

> *Roehm* v. *Horst,* 178 U.S. 1, 17.
> *Central Trust Co.* v. *Chicago Auditorium,* 240 U.S. 581, 589.
> *Moore* v. *Security Trust &c. Co.,* 168 Fed. 496 (C.C.A. 8).

The holder of an insurance policy containing disability benefit provisions has no obligation resting upon him. He is required to do nothing. This was recognized by

Judge Denison in his dissent in the *Rascoe* case (12 F. (2d) 697). The majority in that case sought to bring the case within the rule by construing the *condition* that to recover the policyholder must furnish proof of his disability as an *obligation* to do so (12 F. (2d) 696). Obviously that is an improper construction. This Court considered the point in the *Mobley* case. It said (295 U.S. at 637, 638):

> "The insurer's promise to pay monthly benefits was conditioned on two events: the insured's disability as defined, and the specified proof. Its obligation was not an unqualified one to pay or to pay on the mere occurrence of disability but only after proof of that fact. Similarly its agreement to continue payments once begun was conditioned upon the persistence of insured's disability and, at the election of the insurer, proof of that fact by physical examination, but after two years not oftener than once a year. These conditions serve to define the insurer's promises but impose no obligation on the insured. By payment of the premium he acquired the options and privileges specified. He did not promise or in any manner bind himself to do or refrain from doing anything. The provision that the company may require proof of continuance of disability conditions the right of the insured to have future installments but imposes no obligation upon him. He was at liberty, without breach of contract, to refrain from making the claim or to refuse disclosure of his condition or to permit examination."

The entire absence of obligation on the part of the policyholder makes the doctrine of anticipatory breach entirely inapplicable.

See *Killian* v. *Metropolitan Life Ins. Co.*, 251 N.Y. 44, 48.

Since the declaration does not show a repudiation by the petitioner of a mutually executory contract, there can be no recovery on the theory of anticipatory breach. It does show a cause of action for present breach—but one on which only $98 can be recovered. The breach shown consists only of failure to pay accrued benefits. It cannot affect further obligations which, though they may or may not arise in the future, have not yet accrued. In this the Circuit Court of Appeals fell into error. That Court wholly failed to appreciate the nature of the obligation of the petitioner under this contract. It considered the case as one within the rule of *Parker* v. *Russell,* 133 Mass. 74, and *Pierce* v. *Tennessee Coal &c. Co.,* 173 U.S. 1, both *supra* (see R. 15). It did not recognize that there was no accrued obligation on the petitioner with reference to future months. Its judgment overruling the demurrer was, consequently, erroneous.

3. Aside from the rules of law heretofore discussed, it would be unjust to permit the recovery sought by the respondent.

Prior to the decision in the *Rascoe* case, 12 F. (2d) 693 (C.C.A. 6), no Federal Court had permitted recovery of damages based upon future disability payments which might or might not accrue, depending upon whether the insured continued to live and suffer. The opinion of the Circuit Court of Appeals in the present case is the first since the *Rascoe* case which permits such recovery.* This

*The following are all of the cases in which the *Rascoe* case has been cited: In *Schmitt* v. *Mass. Protective Assn.,* 32 F. (2d) 61 63 (C.C.A. 8), it was referred to as cited by the defendant; it was not applied or followed. In *Parks* v. *Maryland Cas. Co.,* 59 F. (2d) 736, 737 (D.C. W.D. Mo., W.D.), it was distinguished and the dissent commended. The Court held there could be no recovery of future disability benefits. In *Kithcart* v. *Metropolitan Life Ins. Co.,* 1 Fed. Supp. 719 (D.C. W.D. Mo., W.D.), it was distinguished and the *Parks* case was followed. In *Wyll* v.

Court in the *Mobley* case at the conclusion of its opinion said (295 U.S. 639):

> "We conclude that, as found by the lower courts—rightly declining to follow the decision of the Circuit Court of Appeals for the Sixth Circuit in *Federal Life Ins. Co.* v. *Rascoe, supra,* 696—the company did not repudiate the policies. In view of that fact, we need not, and therefore do not, decide whether the doctrine of anticipatory breach is applicable to the class of cases to which this one belongs. *Dingley* v. *Oler, ubi supra.*"

Reasons, which seem compelling to the petitioner, have already been given why the doctrine of anticipatory breach cannot apply to cases like the present. In addition there are practical reasons against its application which merit the consideration of the Court.

At the outset it is to be observed that the insurer never agreed in the policy to pay a lump sum. What it agreed

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Pacific Mutual Life Ins. Co., 3 Fed. Supp. 483, 484 (D.C. N.D. Tex., Dallas Div.), it was again distinguished and the dissent commended. In *Menssen* v. *Travelers Ins. Co.*, 5 Fed. Supp. 114, 115, 116 (D.C. E.D. N.Y.), its reasoning was questioned and the *Wyll*, *Kithcart*, and *Parks* cases were followed. The same was true in *Ginsburg* v. *Pacific Mutual Life Ins. Co.*, 5 Fed. Supp. 296 (D.C. S.D. N.Y.). In *Mobley* v. *New York Life Ins. Co.*, 74 F. (2d) 588, 590 (C.C.A. 5), it was not followed, and numerous of the state cases disapproving it were referred to. In *Davies* v. *Sun Life Assur. Co.*, 2 Fed. Supp. 955, 957 (D.C. W.D. Wash., N.D.), it was referred to without comment as cited by the plaintiff. A motion to remand was denied on the ground that there was enough diversity in the cases on the point to raise some question. This case was disapproved in the *Menssen* case, *supra.* In *Prudential Ins. Co.* v. *Faulkner,* 68 F. (2d) 676, 680 (C.C.A. 10), a case dealing with the payment of the face of the policy as a disability benefit, it was discussed at some length and without enthusiasm. It is difficult to discover any opinion of a Circuit Court of Appeals which has received such a chilly reception by the Courts.

to do and what the insured bargained for was that it should make payments monthly. The object of those payments, of course, was to provide a current income to the insured while disabled from earning. If the insured, instead of receiving that monthly income, receives one lump sum, the entire scheme of the contract is defeated and he receives something very different from what he bargained for. In the absence of controlling reasons this should not be permitted.

Whatever might be the situation where the insurer went out of business (cf. *Lovell* v. *St. Louis Mutual Ins. Co.*, 111 U.S. 264) and so made it impossible for the insured to receive his bargain, or where the insurer in bad faith harassed the insured by repeated and vexatious refusals to pay, in a case like the present there are no such compelling reasons for permitting such speculative damages. There has been one refusal to pay upon the ground that nothing was due (see *Kimel* v. *Missouri State Life Ins. Co.*, 71 F. (2d) 921, 923, *supra; Daley* v. *People's Building &c. Assn.*, 178 Mass. 13). There are no allegations suggesting that, if it shall be determined that the respondent is really disabled, the petitioner will not accept that determination. If on the 11th days of August, September, and October, 1933, the respondent was totally disabled, he should receive $20 for each of those months. And the same applies to each month since then. But there is no sound reason why he should instead now receive $15,900.

The fundamental reason generally advanced as the ground for the doctrine of anticipatory breach is the practical convenience which it affords.

See 3 Williston, Contracts, § 1321.

Here there is no practical convenience. Instead of assisting the plaintiff speedily to obtain what he should receive,

he is given something he never bargained for in its place. The rule should never be pushed beyond its reason.

Justice, therefore, does not require that a plaintiff have this novel remedy. But further, to give it to him is to do injustice to the defendant. The entire damages which the plaintiff would receive must be based very largely indeed upon conjecture. Those which the respondent sought here are based upon his life expectancy. He assumes (R. 7) that he will live 432 months (36 years) *and* that he will continue to be totally disabled throughout each one of those 432 months. There is no way in which that can be proved. Life expectancy tables, as the Court knows judicially, apply only to normal lives. On his own showing the respondent's is an impaired life. The only known method of making a prophecy, acceptable to the law, that the respondent will live thirty-six years, or ten years, or one year cannot therefore apply in this sort of case. And that is only half of the case. To recover these damages the respondent must not only show he will live, he must also show that he will continue *totally* disabled. On this there is no possible ground on which to found a prophecy. Physicians can speculate, but that does not satisfy the law. The matter was put somewhat quaintly by the attorney general *arguendo* in *Chesterfield* v. *Janssen,* 1 Atk. 301, 329, when he said:

> "Physicians are not certain, nor infallible; they pronounce people dead and yet they recover and bite them."

If an insurer is now required to pay a large sum upon the chance (which cannot be determined by any legal proof) that an insured will continue disabled, it obviously is highly probable that it will be required to pay more than if it is held to the letter of its contract and required to keep up

the monthly annuity. Damages for breach of contract are supposed to compensate the plaintiff, not penalize the defendant. For example, where suit is brought upon an alternative contract, damages are given upon the least onerous alternative.

Restatement, Contracts, § 344:

> "The damages for breach of an alternative contract are determined . . . in case of breach without an election, in accordance with the alternative which will result in the smallest recovery."

In the absence of controlling reasons the insurer should not be subjected to any such hazard.

One result of this hazard, if such actions are to be allowed, is that it places the insurer in an extremely dangerous position in all disability cases. The Court is, of course, aware of the great volume of litigation arising out of disability insurance. There are hosts of policyholders who are suffering from some measure of disability. In each case it may well be a matter of opinion as to the degree of disability. If the policyholder claims benefits which the insurer denies are due him, every consideration of justice requires that the Courts be open to the insurer to litigate the dispute.

Kimel v. *Missouri State Life Ins. Co.*, 71 F. (2d) 921 (C.C.A. 10), *supra.*
Daley v. *People's Building &c. Assn.*, 178 Mass. 13.

The insurer has no desire to repudiate its contract; it simply wishes to limit its payments to its obligations. But if a denial of the disability, if wrong in fact, constitutes a breach of the contract which will enable the insured immediately to recover total damages, it will require considerable hardihood on the part of the insurer to exercise its

undoubted right to litigate the question. It is one thing to litigate a case involving at most a few hundred dollars. It is quite a different thing where many thousands are at stake.

Moreover, there are many cases in which an insurer within the contestable period receives a claim for disability which upon investigation shows ground for believing that the entire policy was so obtained as to be voidable. Public policy requires that the insurer have the opportunity to litigate that question and avoid the policy if its contention is well founded.

> *Reagan* v. *Union Mutual Life Ins. Co.*, 189 Mass. 555.
>
> *New York Life Ins. Co.* v. *Hardison*, 199 Mass. 190.

But will it dare try if the result is to subject it to present liability for a large sum if the contention proves not well founded? This is a greater hardship yet. In the first case, where there is a simple denial of disability, there is no repudiation of the contract. That is settled by the *Mobley* case. But in this second case there is a clear repudiation. The result of allowing recovery of entire damages in that situation is to make unduly hazardous the resort to the Courts which public policy requires shall be open to the insurer.

> See *Cobb* v. *Pacific Mutual Life Ins. Co.*, 51 Pac. (2d) 84, 88 (Calif. Supreme Court, Oct. 31, 1935).

Here again there is no hardship on the insured in denying recovery of something he never bargained for. If the question of whether the policy can be avoided is decided in his favour, he has the policy he thought he had and will receive the benefits he purchased. He will have lost nothing.

He certainly should be made whole, but as certainly the insurer should not be penalized for making the *bona fide* contest from which public policy says he shall not disable himself.

We urge these practical considerations on the Court. Save for the *Rascoe* case (12 F. (2d) 693), there is no authority in the Federal books permitting present recovery for future disability benefits where the insurer continues in business and acts in good faith. The *Rascoe* case has been cited only to be distinguished. It is poorly reasoned and reaches its result by a distorted construction of policy provisions. There is a strong dissenting opinion from an eminent judge. We submit that it is no authority and that the matter is now to be considered as *res integra*. In that situation practical considerations of hardship on the defendant and lack of benefit to the plaintiff are entitled to great weight. The Court should, we submit, hesitate to extend the doctrine of anticipatory breach, which is based upon practical convenience, to a class of contract to which it has not been applied before and to a sort of case in which it affords no practical convenience, but, on the contrary, results in great practical hardship.

Respectfully submitted,

LOUIS H. COOKE,
F. H. NASH,
RICHARD WAIT.